PATIENT INITIAL INFORMATION

Patient Name:____________________ Date of Birth:____________ Gender: ____________

Social Security Number:__________________ Marital Status:______ Date of Injury:____________

Address:____________________ City:_______________ State:_____ Zip Code:_____

Home Phone Number:____________________ Cell Phone Number:__________________

Email Address:____

Employer:__________________________ Work Phone Number:__________________

Emergency Contact:__________________ Relationship:____________ Phone Number:____________

Referring Physician:__________________ Primary Care Physician:________________________

People with whom we may discuss your medical care:____________________________________

Would you prefer to be notified, regarding your appointment, via: text message, e-mail message. Please circle.

Primary Insurance________________ Insured Person____________________ Insured DOB____________

Please indicate insured's relationship to patient: Self / Spouse / Parent

Secondary Insurance______________ Insured Person ____________________ Insured DOB____________

Please indicate insured's relationship to patient: Self / Spouse / Parent

Have you had any therapies-physical, occupational or chiropractic-in the last twelve (12) months?

If so, where and how many visits?____

No-Show Cancelation Policy

The following are our policies regarding cancelations and no-shows. Your referring doctor and/or your therapist have established a plan of care that includes the frequency of treatment. Attending your scheduled therapy is very important for you to progress to your goals in treatment.

- **We require 24-hour advanced notice in the event of a cancelation. No-Show appointments, or cancellations not received before the 24-hour threshold, will result in a $50 charge.**
- **No-show appointments and appointments that are canceled the same day of the appointment are documented in your medical record and are reported to your referring physician on your next updated progress report to your physician.**
- **For Worker's Compensation and Personal Injury patients, documents of any missed or canceled appointments are forwarded to your case manager and referring physician.**

Patient Signature: ____________________________ Date: ______________

Witness: __________________________________ Date: ______________

Patient Health Questionnaire

Patient's Name______________________________ **Today's Date**__________

This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and your referring physician give you the best possible care. Please answer every question as accurately and thoroughly as you can.

Age__________ **Height**__________ **Weight** __________ **Occupation** __________

Have you had a flu vaccine? Yes_____ No _____. If yes, when was your flu vaccine:__________

Have you had a pneumonia vaccine Yes_____ No_____. If yes, when was your pneumonia vaccine:__________

What is your chief complaint? (diagnosis, symptoms, or condition)__________

Medical History (please check if you have any of the following:)

___Allergies
___Anemia
___Anxiety
___Arthritis
___Asthma
___Autoimmune Disorder
___Cancer
___Cardiac Condition
___Cardiac Pacemaker
___Drug/Alcohol Abuse
___Circulation Problems
___Currently Pregnant
___Depression
___Diabetes
___Dizzy Spells
___Emphysema/Bronchitis
___Fibromyalgia
___Fractures
___Gallbladder Problems
___Headaches
___Hearing Impairments
___Hepatitis
___High Cholesterol
___High/Low Blood Pressure
___HIV/AIDS
___Incontinence
___Kidney Problems
___Metal Implants
___MRSA
___Multiple Sclerosis
___Muscular Disease
___Osteoporosis
___Parkinson's
___Rheumatoid Arthritis
___Seizures
___Smoking
___Speech Problems
___Strokes
___Thyroid Disease
___Tuberculosis
___Vision Problems

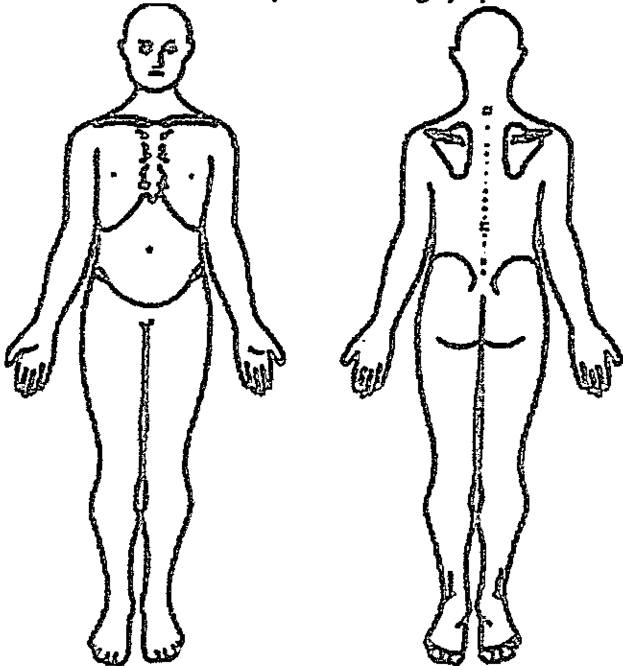
If you checked any of the above conditions, please explain and give approximate dates and describe any other conditions not listed above:__________

____

Is the injury due to a fall?__________ **Have you had 2 or more falls in the last year?**__________

Do you have a fear of falling?__________

Please indicate where you are having symptoms



Please list any medications (with dosage and frequency) you are currently taking:__________

____

____

On a scale of 0-10, please rate your pain:

Current pain_______ worst pain______ best pain______

When is your pain at its worst? __________

Is it constant or intermittent? __________

How would you describe your pain/symptoms?

___sharp ___shooting ___aching ___dull
___numbness ___tingling ___burning
___throbbing ___other:__________

What tests have you had for this problem?

Xray_______ MRI_______ CT_______ EMG_______
Other:__________

Have you ever had surgery for this problem?(If yes, please list date of surgery)__________

Please list any other surgeries you have had:__________

____

____

Please check any activities you are having trouble doing due to your injury or symptoms:

___sleeping ___bed mobility ___dressing
___bathing ___sitting ___standing
___walking ___running ___bending
___housework ___computer use ___driving
___jumping ___changing direction ___lifting
___squatting ___reaching overhead ___stairs
___transfers ___reaching behind back
___sport activity:__________
___work related activity:__________
___other:__________

Advanced Physical Therapy, PLLC

4301 MacCorkle Avenue, SE. Charleston, WV 25304

304-720-9185, Fax 304-720-9186

PRACTICE POLICIES

We offer, as a service for our patients, the option of billing your insurance. We will contact your insurance company on or near the initial date of service to verify coverage. However, benefit verification is not a guarantee of payment.

DEDUCTIBLES AND CO-PAYMENTS:

Deductibles and co-payments are due at the time of service. Unpaid balances left by your insurance companies will be your responsibility. Please contact our billing specialist if you would like to arrange a monthly payment plan.

FINANCIAL RESPONSIBILITY:

If you do not have any insurance coverage, payment is expected at the time of service. Those accounts not paid in full after 30 days may be listed with a collection agency, unless other arrangements are made. We accept cash, checks and most credit cards.

WORKER'S COMPENSATION:

Patients who are covered under Worker's Compensation are required to provide the following: exact date of injury, claim numbers, billing address and any authorizations required for treatment and/or services to be rendered. You, the patient, or the authorizing party must provide these. If all the above information is not provided, you, the patient, will be responsible for any charges incurred.

LITIGATION:

The patient has the following options: 1) bill your automobile or liability insurance, 2) bill your health insurance or 3) payment in full at the time of service. For any unpaid balance, we will require good-faith payment from the patient each month until settlement is reached and the account is paid in full. REMEMBER: Any unpaid balance will be the responsibility of the patient and subject to listing with a collection agency after 30 days of non-payment.

Patient's Signature: ________________ Date: ________ Witness's Signature: __________

Advanced Physical Therapy

<u>Privacy Practices</u>

Acknowledgment Form

Name: (Print) ______________________________ Birth Date: __________

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

This is my authorization of consent for medical services rendered.

This is my authorization for the release of medical information necessary to process my claim, and/or to obtain medical information from other providers.

This is my authorization for the insurance company to pay directly to the provider of service.

I understand and agree I am responsible for balances or services not covered by insurance, attorneys, etc.

Signature: __________________________________ Date: ______________

Witness: ____________________________________ Date: _____________

ADVANCED
PHYSICAL THERAPY

CONSENT FOR PHYSICAL THERAPY

Date: ______________ Time: ____________________

1. I, __________________, am entering Advanced Physical Therapy, PLLC, voluntarily for the purpose of physical therapy treatments, and do hereby consent to such treatment.
2. I hereby authorize advanced Physical Therapy, PLLC, to complete any insurance forms and release any information, be it verbal or written, including the diagnosis and records of any treatment or examinations rendered to me, submitted to them in connection with physical therapy. This authorization is valid unless otherwise revoked, via written form, by myself.
3. I agree the Advanced Physical Therapy, PLLC shall not be liable or responsible for the loss or damage to any articles or personal property having a monetary value.
4. I understand that a payment in full for medical supplies is due at the time of treatment. I understand that payment in full for durable medical supplies is due prior to receipt of the equipment.
5. Advanced Physical Therapy, PLLC will make every effort to provide adequate privacy. If you feel additional privacy is necessary, please inform our staff.
6. This form has been fully explained to me, and I certify that I understand its contents.

____________________________ ____________________________________

****Signature of PATIENT WITNESS

If the patient is unable to consent or is a minor, complete the following:

____ Patient named above is a minor ______years of age

____ Patient named above is unable to sign because ____________________

For this reason I am signing on behalf of the patient named.

____________________________ ____________________________________

Signature of Guardian or Relative WITNESS